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Parent Questionnaire

Child's Name: _________________________ Parent/Guardian Name: __________________________

Date of Birth: __________________________ Relationship to Child: ____________________________

Child's Age: ___________________________ Today's Date: ___________________________________

Primary Concerns

What brought you to seek therapy for your child? In what areas of daily life does your child struggle? Feel free to be general or specific.

____

____

In one year, it would be amazing if my child could...

____

____

What do you see as your child's strengths?

____

____

In one sentence, how would you describe your child?

____

____

Medical History

Briefly describe your child's relevant medical history. Include *pregnancy, weeks of gestation, delivery, baby's weight, any hospitalizations or surgeries, significant illnesses, accidents or traumas, history of ear infections and/or tubes, and history of upper respiratory infections*. Include approximate dates or child's age when possible.

____

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____

____

Has your child been given any diagnoses? If so, please list and include child's age:

____

____

List any medications and reason. Include any additional vitamins, herbal, homeopathic, or other supplements:

____

____

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List any allergies or other precautions we need to be aware of:

____

____

Treatment History

What have you done already to try and help your child with the struggles you've listed? Has your child had OT or PT in the past? If so, where were the therapy services and what results did you notice?

____

____

Names of professionals who work (have worked) with my child:

Specialist Physician ________________________ Dev'l Optometrist __________________________

Physical Therapist _________________________ Occupational Therapist ______________________

Speech Therapist __________________________ Orthopedist ______________________________

Psychologist/Behaviorist/Counselor ____

School Performance

Type of school: (public, private, homeschool): ____

Grade (by age): ________ Approx. grade level for reading: ________ Writing: _______ Math: _______

Describe how your child does in school. Where are the struggles (academically, physically, socially)?

____

____

What comes easily? How well does your child like school?

____

____

Developmental History

Approximately how old was your child at the following developmental motor milestones?

Hold head up	____________________________
Roll	____________________________
Sit unsupported	____________________________
Crawl	____________________________
Stand	____________________________
Walk	____________________________
Run	____________________________
Jump with two feet together	____________________________
Hop on one foot	____________________________
Skip	____________________________
Ride tricycle	____________________________
Ride bicycle w/ training wheels	____________________________
Ride bicycle w/o training wheels	____________________________
Potty trained	____________________________

Self-Care Skills

Which of the following can your child already do without help?

☐ Undress
☐ Unfasten buttons ☐ large ☐ small
☐ Unfasten snaps
☐ Unfasten zippers on jacket
☐ Unzip and zip up a backpack
☐ Fasten buttons ☐ large ☐ small
☐ Fasten zipper on own jacket
☐ Brush hair
☐ Wash hands ☐ with help ☐ by self
☐ Pour ☐ with spilling ☐ without spilling
☐ Help set the table
☐ Clean up toys when requested

☐ Get dressed ☐ with correct front/back
☐ Tie a knot with laces
☐ Tie a bow ☐ "bunny ears" ☐ traditional bow
☐ Use a spoon ☐ with spilling ☐ without spilling
☐ Use a fork
☐ Cut with fork & knife ☐ soft foods ☐ most foods
☐ Use cup ☐ with spilling ☐ without spilling
☐ Use straw ☐ Blow bubbles
☐ Brush teeth ☐ with help ☐ by self
☐ Make a snack
☐ Make a simple meal
☐ Make the bed

Does your child have strong food preferences or avoid certain textures of food? If yes, please describe.

____

____

Social History & Behavior

What languages are spoken in the home? ______________________________

What is your child's primary language? ______________________________

Who lives with the child? Give ages of other children in the home.

____

____

Who does your child prefer to be around in social situations?

☐ younger children ☐ same-aged children ☐ older children ☐ adults ☐ familiar people

Does your child follow instructions on request? Usually Occasionally Rarely No

How many step-directions is your child able to follow? 0 1 2 3+

Do you have significant concerns about your child's behavior? If so, please describe.

____

____

Sensorimotor History

	Does the child:	No	Yes	Unknown
	1) Have any diagnosed muscle pathology (e.g. low tone, high tone, CP)	___	___	___
Muscle Sensation	2) Seem weaker than normal	___	___	___
	3) Frequently grasp objects too tight	___	___	___
	4) Have a weak grasp	___	___	___
	5) Get tired easily	___	___	___

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	Does the child:	No	Yes	Unknown	
Coordination	1) Have difficulty manipulating small objects	___	___	___	
	2) Seem clumsy or accident prone	___	___	___	
	3) Eat in a sloppy manner	___	___	___	
	4) Have difficulty with pencil activities	___	___	___	
	5) Neglect one side of the body or seem unaware of it	___	___	___	

		No	Yes	Unknown	
Reflex Integration & Development	1) Was the child slow to reach the usual milestones (e.g. sitting, crawling, walking)	___	___	___	
	2) Often anxious or restless	___	___	___	(Moro)
	3) Excessively ticklish	___	___	___	(SG)
	4) Bed-wetting or accidents after age 7	___	___	___	(SG)
	5) Seem overly sensitive to sound	___	___	___	(Moro)
	6) Act helpless / withdrawn / cry easily	___	___	___	(FP)
	7) Toe walk most of the time	___	___	___	(STNR)
	8) Difficulty with transitions / hate surprises	___	___	___	(FP/Moro)
	9) Hate handwriting / very messy handwriting	___	___	___	(Grasp/ATNR)
	10) Hold crayon or pencil too tight	___	___	___	(Grasp)
	11) Difficulty concentrating	___	___	___	(TLR/STNR/ATNR)
	12) Dislike sports / prefer to watch on playground	___	___	___	(TLR)
	13) Poor organizational skills / scattered	___	___	___	(TLR/STNR)
	14) Difficulty reading / skip lines	___	___	___	(ATNR)
	15) Have a lack of hand dominance / switch hands	___	___	___	(ATNR)
	16) Poor posture / slouching	___	___	___	(STNR)
	17) Significant difficulty getting ideas on paper	___	___	___	(ATNR)
	18) Easily carsick / fear of heights	___	___	___	(TLR)
	19) Difficulty copying from the board	___	___	___	(TLR/STNR)
	20) Sensory Processing Disorder / sensory issues	___	___	___	(FP/Moro,/ATNR/STNR)

Comments or further explanation about any of the above:

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What else would you like for the therapist to know about your child?

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